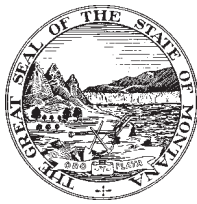


**FORM 2**  
**MEDICAL EVALUATION FOR DRIVER**  
**LICENSE MAIL RENEWAL**  
**APPLICATION**



**MONTANA DEPARTMENT OF JUSTICE**  
**DIVISION OF MOTOR VEHICLES**  
Phone: (406) 444-4590, Fax: (406) 444-7623

**Please Return Form To Patient**

Name (Last, First, Middle):	Driver License #:	Date of Birth:
Street Address:	City: State: Zip Code:	Daytime Phone #:

**INTRODUCTION TO PHYSICIAN:**

Montana State Law, Mont. Code Ann. § 61-5-111(3)(d)(ii), requires a medical evaluation form to be completed by a licensed physician.

Pursuant to Montana State Law, Mont. Code Ann. § 61-5-207, **REEXAMINATION OR MEDICAL EVALUATION - WHEN REQUIRED**, a Montana driver license may be denied if it is determined that additional medical evaluation or license testing is required.

Please indicate, to the best of your knowledge, if your patient may have any conditions that could affect the safe operation of a motor vehicle. Complete the sections below and return to patient.

**1. IMPAIRMENTS THAT ARE PRESENTLY SHOWN BY YOUR PATIENT:**

Yes No

- ☐ ☐ Sporadic loss of conscious awareness
- ☐ ☐ Loss of consciousness
- ☐ ☐ Impaired motor functions
- ☐ ☐ Neurological or neuromuscular disease
- ☐ ☐ Diminished concentration
- ☐ ☐ Reaction, or impairment due to change in medication or dosage
- ☐ ☐ Other metabolic disorder

Yes No

- ☐ ☐ Diminished judgement
- ☐ ☐ Memory Loss
- ☐ ☐ Alzheimer's disease
- ☐ ☐ Confusion
- ☐ ☐ Other dementia

Comments: \_\_\_\_\_

**2. TO THE BEST OF YOUR KNOWLEDGE, ARE THERE ANY IMPEDIMENTS THAT SUGGEST YOUR PATIENT MAY HAVE A PROBLEM DRIVING A MOTOR VEHICLE?**

Yes No

☐ ☐ If yes, please describe: \_\_\_\_\_

**3. DO YOU RECOMMEND ANY DRIVING RESTRICTION OR ADAPTIVE EQUIPMENT TO ASSIST YOUR PATIENT WITH OPERATING A MOTOR VEHICLE?**

Yes No

☐ ☐ If yes, please describe: \_\_\_\_\_

**LICENSED PHYSICIAN/PROVIDER:**

Signature:	Name (printed):	Date:
Type of Practice: Medical License#:	Address (include city, state, & zip):	Phone #: